The use of Enhanced Recovery after Surgery (ERAS) to decrease length of stay and increase patient satisfaction: An integrative Research Review

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Background & Significance

- In a day and age where reimbursement for medical practices is tied to patient satisfaction, it is essential to emphasize patient satisfaction when looking at outcomes in relation to interventions.
- Data on hospital-based surveys link patient care, patient satisfaction, and reimbursement (Price et al., 2014).
- The most commonly used survey is the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS), also known as H-Caps. The data derived from this metric determines reimbursement based on the patient experience.
- The premise underlying the survey is the notion quality outcomes and high levels of patient satisfaction lead to quality improvements and better reimbursement (Price et al., 2014).

Research Question

In the postoperative patient will adherence to Enhanced Recovery after Surgery or ERAS practices decrease length of stay (LOS) and improve patient satisfaction? (Price et al., 2014)

Methodology

- Keywords “ERAS or enhanced recovery after surgery,” “patient satisfaction,” and “length of stay”
- Inclusion Criteria “peer-reviewed,” “academic journal” between the years of 2014-2019.
- Exclusion Criteria “non academic articles” years later than 2014.

Results

- 139 articles identified with 44 duplicates resulting in 95 total articles being critically appraised using evaluative checklists and the EBR tool.
- 83 articles were excluded due to irrelevance, reducing the total number to 12 manuscripts for review.

Literature Synthesis

- ERAS programs focus on reducing perioperative stress, achieving pain control, resumption of normal gastrointestinal function, and early mobilization (Miralpeix et al., 2016, Springer et al., 2018, Kalogera et al., 2018, Keller et al., 2016, Cui et al., 2016, Thiele et al., 2012).
- ERAS pathways are multimodal, multidisciplinary care pathways to promote earlier recovery after surgical procedures by maintaining baseline organ function, while reducing the stress response and maintaining homeostasis (Thiele et al., 2011, Miralpeix et al., 2016, Springer et al., 2018, Keller et al., 2016, Frees et al., 2016, Zhang et al., 2016, Keller et al., 2016, Kalogera et al., 2018).
- Consistent findings were limitation of preoperative fasting, patient-specific analgesia (including epidurals to avoid excessive narcotic use), least invasive surgery approaches, and early postoperative ambulation and feeding (Miralpeix et al., 2016, Springer et al., 2018, Kalogera et al., 2018, Zhang et al., 2016, Keller et al., 2016, Cui et al., 2016, Thiele et al., 2012).

Discussion

- Implementation of this multimodal, multidisciplinary pathway is posing difficult due to lack of standardization (Kalogera et al., 2018, Keller et al., 2016, Martin et al., 2018, Thiele et al., 2012), requiring clear communication across multiple disciplines (Kalogera et al., 2018, Springer et al., 2018, Cui et al., 2016, Martin et al., 2018, Thiele et al., 2012) and with lack of Nursing support (Springer et al., 2018, Keller et al., 2016, Martin et al., 2018).
- Identified barriers to ERAS utilization are inadequate staffing and lack of nursing time. (Ronald et al., 2015, Alawadi et al., 2016, Martin et al., 2018).
- Both barriers present challenges to nursing practice.
- ERAS represents best clinical practice and has been adopted across many surgical specialties; however, further efforts are needed to standardize pathways to encourage widespread implementation to decrease length of stay and improve patient satisfaction (Kalogera et al., 2018, Zhang et al., 2016, Keller et al., 2016, Thiele et al., 2012).

References